RATES AND PLANS FOLDOUT

	HMO's Coventry HMO Preferred Plus of Kansas, HMO Premier Blue, HMO	PPO's Coventry PPO Kansas Choice, PPO	PPO's Coventry PPO Kansas Choice, PPO	QHDHP Coventry QHDHP w/Health Saving Account	QHDHP Coventry QHDHP w/Health Saving Account
		Network providers	Non network providers	Network providers	Non network providers
BASIC PROVISIONS					
Coinsurance	10% paid by member	35% paid by member	50% paid by member	20% paid by member	40% paid by member
Coinsurance Maximum	$1,000 single/$2,000 family	$2,200 single/$4,400 family	$3,650 single/$7,300 family	$5,000 single/$10,000 family	$6,000 single/$12,000 family
Deductible: *not included in coinsurance maximums*				*Note: When selecting any level of dependent coverage, the entire family deductible must be met before claims are paid for any covered person.*	
Single/Family	n/a	$0 Single /$0 Family	$500 single/$1,500 family	$1,500 single/$3,000 family	$2,000 single/$4,000 family
Copayments: *not included in coinsurance maximum*					
Physician office visit	$20 PCP / $30 Specialist	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Emergency room	$75	$100	$200	Deductible & coinsurance	Deductible & coinsurance
Urgent care	$30	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Hospital admission	$200	$300	$600	Deductible & coinsurance	Deductible & coinsurance
Outpatient mental health: *not biologically based*	$25	$25	$25	Deductible & coinsurance	Deductible & coinsurance
Outpatient surgery	$100	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Major diagnostic tests	$100	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Lifetime Benefit Maximum	$3,000,000 per person	$3,000,000 per person	$3,000,000 per person	$5,000,000 per person	$5,000,000 per person
Primary Care Physician (PCP)	PCP manages all care	PCP not required	PCP not required	PCP not required	PCP not required
Provider Choice	Local network: referrals required by Primary Care Physician for care by any other provider	Freedom to use provider of choice, benefits based on plan description: **coverage level** based on provider network status	Freedom to use provider of choice, benefits based on plan description: **coverage level** based on provider network status	Freedom to use provider of choice, benefits based on plan description: **coverage level** based on provider network status	Freedom to use provider of choice, benefits based on plan description: **coverage level** based on provider network status
Non Network Care	Covered only for initial treatment of medical emergency or if pre-approved by health plan	n/a	Deductible, coinsurance, & copay	n/a	Deductible & coinsurance
Out of Area Care	Must be referred by PCP and pre-approved by health plan.	Coinsurance	Deductible, coinsurance, & copay	Deductible & coinsurance	Deductible & coinsurance
Amounts Above Plan Allowance	Provider to write off	Provider to write off	Member responsibility	Provider to write off	Member responsibility
COVERED SERVICES					
Inpatient Services	Copay & coinsurance	Copay & coinsurance	Deductible, coinsurance, & copay	Deductible & coinsurance	Deductible & coinsurance
Physician Hospital Visits	Coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Physician Office Visits					
Primary Care Physician (PCP)	$20 copay	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Specialist	$30 copay	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Urgent care center	$30 copay	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Outpatient Surgery	$100 copay per surgery, then coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Emergency Room Visits	$75 copay (waived if admitted) then coinsurance	Copay & coinsurance	Deductible, coinsurance, & copay	Deductible & coinsurance	Deductible & coinsurance
Other Outpatient Services	Coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Ambulance Services	Coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Major Diagnostic Tests**	$100 copay per test per day, then coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Home Health Care	Services must be pre-approved by health plan; limited to $5,000/ benefit period; coinsurance	Services must be pre-approved by health plan; limited to $5,000/ benefit period; coinsurance	Services must be pre-approved by health plan; limited to $5,000/ benefit period; deductible & coinsurance	Services must be pre-approved by health plan: deductible & coinsurance	Services must be pre-approved by health plan: deductible & coinsurance
Hospice	Services must be pre-approved by health plan; limited to $7,500/ lifetime; coinsurance	Services must be pre-approved by health plan; limited to $7,500/ lifetime; coinsurance	Services must be pre-approved by health plan; limited to $7,500/ lifetime; deductible & coinsurance	Services must be pre-approved by health plan: deductible & coinsurance	Services must be pre-approved by health plan: deductible & coinsurance
X-Ray and Laboratory	Coinsurance	Coinsurance	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
Physical Rehabilitation Services: *including chiropractic care*	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement	Services limited to those medically necessary and appropriate: medical records must show continued improvement
Inpatient facility	Copay & coinsurance: must show continued improvement	Copay & coinsurance; must show continued improvement; must be pre-approved by health plan	Deductible, coinsurance, & copay: must show continued improvement; must be pre-approved by health plan	Deductible & coinsurance: see schedule of benefits	Deductible & coinsurance: see schedule of benefits
Outpatient facility	Coinsurance: must show continued improvement	Coinsurance: must show continued improvement	Deductible & coinsurance: must show continued improvement	Deductible & coinsurance: see schedule of benefits	Deductible & coinsurance: see schedule of benefits
Office based	Copay & coinsurance: limited to 30 visits per year	Coinsurance: limited to 30 visits per year	Deductible & coinsurance: limited to 30 visits per year	Deductible & coinsurance: see schedule of benefits	Deductible & coinsurance: see schedule of benefits
Durable Medical Equipment	Services must be pre-approved by health plan; limited to $5,000 per person per year of covered services; coinsurance	Coinsurance; limited to $4,500 per person per year; must be pre-approved by health plan	Deductible & coinsurance; limited to $4,500 per person per year; must be pre-approved by health plan	Deductible & coinsurance: limited to $1,000 per person per year	Deductible & coinsurance: limited to $1,000 per person per year
Allergy Testing	As approved by Primary Care Physician & approved by health plan: Office visit copay & coinsurance	Coinsurance: must be pre-approved by health plan	Deductible & coinsurance: must be pre-approved by health plan	Deductible & coinsurance	Deductible & coinsurance
Antigen Administration: *desensitazation/treatment; allergy shots*	As approved by Primary Care Physician & approved by health plan: Office visit copay & coinsurance	Coinsurance: must be pre-approved by health plan	Deductible & coinsurance: must be pre-approved by health plan	Deductible & coinsurance	Deductible & coinsurance
Infertility Treatment: *limited to testing & three attempts at artificial insemination per year*	As approved by Primary Care Physician & approved by health plan: Office visit copay & coinsurance	Coinsurance: must be pre-approved by health plan	Deductible & coinsurance: must be pre-approved by health plan	Deductible & coinsurance; diagnosis & surgical treatment only; limited to $2,000/year	Deductible & coinsurance; diagnosis & surgical treatment only; limited to $2,000/year
Childhood Immunizations: *to age 5*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
MENTAL HEALTH					
Inpatient Nervous & Mental/Drug & Alcohol	Copay & coinsurance; 60 day limit/year	Copay & coinsurance; 60 day limit/year	Deductible, coinsurance, & copay; 30 day limit/year	Deductible & coinsurance: 60 day limit/year	Deductible & coinsurance: 30 day limit/year
Outpatient Nervous & Mental/	First 3 visits plan pays 100%; next	Both in and out of network visits	Both in and out of network visits	Deductible & coinsurance: limited	Deductible & coinsurance: limited
Drug & Alcohol	22 visits, $25 copay; additional visits @ 50%	will be counted towards first 25 visits: First 3 visits plan pays 100%; next 22 visits, $25 copay; additional visits @ 50%	will be counted towards the 25 visit limit: First 3 visits plan pays 100%; next 22 visits @ 50%	to 30 visits/year	to 30 visits/year
Biologically Based Mental Health Conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions
PREVENTIVE CARE*					
Preventive Care Services	Limited to one per person per calendar year.	First $450/person covered in full, then coinsurance	Not covered	First $450/person covered in full, then deductible & coinsurance	Not covered
Age Appropriate Routine Physical Exam	Must be provided by PCP: copay waived for one visit per person per year	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Well-Woman Care: *office visit, PAP smear test, & STD testing*	Office visit copay; no referral required; must use network provider	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Well-Man Care: *office visit & PSA blood test*	Office visit copay; no referral required; must use network provider	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Mammogram	Covered in full; no referral required; must use network provider	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Dietitian Consultation: *for medical management of a documented disease*	As approved by primary care physician: office visit copay	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Routine Hearing Exam	As approved by primary care physician: office visit copay	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Routine Vision Exam: *refraction exam for glasses; lenses & frames* ***not*** *covered*	Limited to one per year; copay waived for one routine visit per year; no referral required	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Age Appropriate Bone Density Screening	As-approved by primary care physician and approved by health plan: covered in full	Preventive care service allowance, then coinsurance	Not covered	Preventive care service allowance, then deductible & coinsurance	Not covered
Routine Age Appropriate Colonoscopy	As-approved by primary care physician; one per person per lifetime; covered in full. Additional colonoscopy; copay & coinsurance	Preventive care service allowance, then coinsurance; one per person per lifetime. Additional colonoscopy; coinsurance	Not covered: Additional colonoscopy; deductible & coinsurance	Preventive care service allowance, then deductible & coinsurance; one per person per lifetime. Additional colonoscopy; deductable & coinsurance	Not covered: Additional colonoscopy; deductible & coinsurance
PRESCRIPTION DRUG					
Prescription Drug Services	Covered by separate contract with Caremark	Covered by seperate contract with Caremark	Covered by seperate contract with Caremark	Deductible & coinsurance	Deductible & coinsurance
DENTAL					
Dental Services	Covered by separate contract with Delta Dental	Covered by seperate contract with Delta Dental	Covered by seperate contract with Delta Dental	Covered by seperate contract with Delta Dental	Covered by seperate contract with Delta Dental
NON COVERED SERVICES					
TMJ/Orthognathic Surgery	Not Covered under medical: see dental, limited	Not covered under medical: see dental, limited	Not covered under medical: see dental, limited	Not covered under medical: see dental, limited	Not covered under medical: see dental, limited
Orthotics	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect
Gastric Surgery & Other Weight Loss Treatments	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect	Not covered; see KanElect
		Network providers	Non network providers	Network providers	Non network providers
	HMO's Coventry HMO Preferred Plus of Kansas, HMO Premier Blue, HMO	PPO's Coventry PPO Kansas Choice, PPO	PPO's Coventry PPO Kansas Choice, PPO	QHDHP Coventry QHDHP w/Health Saving Account	QHDHP Coventry QHDHP w/Health Saving Account

*** Preventive Care:** For services coded as routine, the preventive care benefits apply. For services coded with a diagnosis, regular benefits apply. Example: If a member goes to their primary care physician for an annual exam and the exam is coded with a diagnosis, the member will be responsible for a $20 office visit copayment. If the annual exam is coded as routine, the exam is covered in full.

**** Major Diagnostic Tests:** includes but not limited to; PET scans, CT scans, nuclear cardiology studies, magnetic resonance angiography, & computerized topography angiography. Most major diagnostic tests require pre-approval by the Health Plan.

The comparison chart is NOT the governing document. Members need to refer to the Certificate of Coverage and Benefit Descriptions posted on the web site at http:www.khpa.ks.gov

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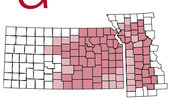

DARK RED, OR HMO & PPO AREAS

	Coventry HMO (1)	Preferred Plus of Kansas, Inc HMO (2)	Premier Blue HMO (3)	Coventry PPO (4)	Kansas Choice PPO (5)	Coventry QHDHP with HSA (6)	Delta Dental	Superior Vision Services - Basic	Superior Vision Services - Enhanced
	1	2	3	4	5	6			
Full-Time 1 - less than $27,000	HMO1	HMO2	HMO3	PPO1	PPO2	QHDHP	DENTAL	BASIC	ENHANCED
Employee Only	30.65	1.38	4.10	19.28	24.12	1.99	0.00	2.18	3.63
Employee & Spouse	149.99	91.47	96.91	127.25	136.93	54.81	7.26	4.36	7.26
Employee & Child(ren)	125.72	73.05	77.95	105.25	113.96	43.84	5.80	3.93	6.53
Employee & Family	242.04	160.11	167.73	210.21	223.76	93.67	13.06	6.10	10.16
Full-Time 2 - $27,000 to $47,000									
Employee Only	35.04	5.77	8.49	23.67	28.51	1.99	0.00	2.18	3.63
Employee & Spouse	158.75	100.23	105.67	136.01	145.69	54.81	7.26	4.36	7.26
Employee & Child(ren)	133.61	80.94	85.84	113.14	121.85	43.84	5.80	3.93	6.53
Employee & Family	254.32	172.39	180.01	222.49	236.04	93.67	13.06	6.10	10.16
Full-Time 3 - more than $47,000									
Employee Only	39.42	10.16	12.88	28.05	32.89	1.99	0.00	2.18	3.63
Employee & Spouse	167.52	109.00	114.44	144.78	154.46	54.81	7.26	4.36	7.26
Employee & Child(ren)	141.51	88.84	93.74	121.04	129.75	43.84	5.80	3.93	6.53
Employee & Family	266.60	184.67	192.29	234.76	248.31	93.67	13.06	6.10	10.16
All Part Time									
Employee Only	70.11	40.85	43.57	58.74	63.58	21.92	3.30	2.18	3.63
Employee & Spouse	210.27	151.75	157.19	187.53	197.21	84.08	11.79	4.36	7.26
Employee & Child(ren)	181.83	129.16	134.06	161.36	170.07	71.25	10.09	3.93	6.53
Employee & Family	318.99	237.06	244.68	287.15	300.70	130.41	18.58	6.10	10.16
HealthyKIDS									
Employee & Child(ren)	66.09	13.42	18.32	45.63	54.34	7.96	1.06	3.93	6.53
Employee & Family	182.42	100.49	108.11	150.59	164.14	57.78	8.31	6.10	10.16

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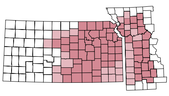

WHITE, OR PPO ONLY AREAS

	Coventry HMO (1)	Preferred Plus of Kansas, Inc HMO (2)	Premier Blue HMO (3)	Coventry PPO (4)	Kansas Choice PPO (5)	Coventry QHDHP with HSA (6)	Delta Dental	Superior Vision Services - Basic	Superior Vision Services - Enhanced
	1	2	3	4	5	6			
Full-Time 1 - less than $27,000	HMO1	HMO2	HMO3	PPO1	PPO2	QHDHP	DENTAL	BASIC	ENHANCED
Employee Only	n/a	n/a	n/a	1.84	6.68	1.99	0.00	2.18	3.63
Employee & Spouse	n/a	n/a	n/a	101.31	110.99	54.81	7.26	4.36	7.26
Employee & Child(ren)	n/a	n/a	n/a	81.01	89.72	43.84	5.80	3.93	6.53
Employee & Family	n/a	n/a	n/a	177.47	191.02	93.67	13.06	6.10	10.16
Full-Time 2 - $27,000 to $47,000									
Employee Only	n/a	n/a	n/a	6.67	11.51	1.99	0.00	2.18	3.63
Employee & Spouse	n/a	n/a	n/a	110.97	120.65	54.81	7.26	4.36	7.26
Employee & Child(ren)	n/a	n/a	n/a	89.71	98.42	43.84	5.80	3.93	6.53
Employee & Family	n/a	n/a	n/a	191.00	204.55	93.67	13.06	6.10	10.16
Full-Time 3 - more than $47,000									
Employee Only	n/a	n/a	n/a	11.50	16.34	1.99	0.00	2.18	3.63
Employee & Spouse	n/a	n/a	n/a	120.63	130.31	54.81	7.26	4.36	7.26
Employee & Child(ren)	n/a	n/a	n/a	98.41	107.12	43.84	5.80	3.93	6.53
Employee & Family	n/a	n/a	n/a	204.53	218.08	93.67	13.06	6.10	10.16
All Part Time									
Employee Only	n/a	n/a	n/a	45.32	50.16	21.92	3.30	2.18	3.63
Employee & Spouse	n/a	n/a	n/a	167.74	177.42	84.08	11.79	4.36	7.26
Employee & Child(ren)	n/a	n/a	n/a	142.85	151.56	71.25	10.09	3.93	6.53
Employee & Family	n/a	n/a	n/a	262.26	275.81	130.41	18.58	6.10	10.16
HealthyKIDS									
Employee & Child(ren)	n/a	n/a	n/a	15.30	24.01	7.96	1.06	3.93	6.53
Employee & Family	n/a	n/a	n/a	111.76	125.31	57.78	8.31	6.10	10.16

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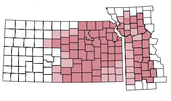
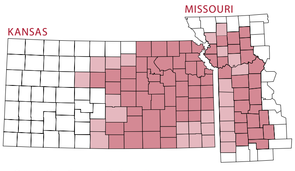


LIGHT RED, OR TRANSITIONAL AREAS

	Coventry HMO (1)	Preferred Plus of Kansas, Inc HMO (2)	Premier Blue HMO (3)	Coventry PPO (4)	Kansas Choice PPO (5)	Coventry QHDHP with HSA (6)	Delta Dental	Superior Vision Services - Basic	Superior Vision Services - Enhanced
	1	2	3	4	5	6			
Full-Time 1 - less than $27,000	HMO1	HMO2	HMO3	PPO1	PPO2	QHDHP	DENTAL	BASIC	ENHANCED
Employee Only	30.65	1.38	4.10	1.84	6.68	1.99	0.00	2.18	3.63
Employee & Spouse	149.99	91.47	96.91	101.31	110.99	54.81	7.26	4.36	7.26
Employee & Child(ren)	125.72	73.05	77.95	81.01	89.72	43.84	5.80	3.93	6.53
Employee & Family	242.04	160.11	167.73	177.47	191.02	93.67	13.06	6.10	10.16
Full-Time 2 - $27,000 to $47,000									
Employee Only	35.04	5.77	8.49	6.67	11.51	1.99	0.00	2.18	3.63
Employee & Spouse	158.75	100.23	105.67	110.97	120.65	54.81	7.26	4.36	7.26
Employee & Child(ren)	133.61	80.94	85.84	89.71	98.42	43.84	5.80	3.93	6.53
Employee & Family	254.32	172.39	180.01	191.00	204.55	93.67	13.06	6.10	10.16
Full-Time 3 - more than $47,000									
Employee Only	39.42	10.16	12.88	11.50	16.34	1.99	0.00	2.18	3.63
Employee & Spouse	167.52	109.00	114.44	120.63	130.31	54.81	7.26	4.36	7.26
Employee & Child(ren)	141.51	88.84	93.74	98.41	107.12	43.84	5.80	3.93	6.53
Employee & Family	266.60	184.67	192.29	204.53	218.08	93.67	13.06	6.10	10.16
All Part Time									
Employee Only	70.11	40.85	43.57	45.32	50.16	21.92	3.30	2.18	3.63
Employee & Spouse	210.27	151.75	157.19	167.74	177.42	84.08	11.79	4.36	7.26
Employee & Child(ren)	181.83	129.16	134.06	142.85	151.56	71.25	10.09	3.93	6.53
Employee & Family	318.99	237.06	244.06	262.26	275.81	130.41	18.58	6.10	10.16
HealthyKIDS									
Employee & Child(ren)	66.09	13.42	18.32	15.30	24.01	7.96	1.06	3.93	6.53
Employee & Family	182.42	100.49	108.11	111.76	125.31	57.78	8.31	6.10	10.16



HOW TO USE THIS CHART

Locate your county of residence in the list to the right.

1. Are you in an "a", "b", or "c" county? The letter of your county tells you which rate chart to use above.

2. The numbers following your county name represent the health plans available in your county. The opposite side of this foldout allows you to compare the plans available to you.

The worksheet on page 15 will aid in choosing the health plan that is best for you.

KEY

1 = Coventry HMO
2 = Preferred Plus of Kansas HMO
3 = Premier Blue HMO
4 = Coventry PPO
5 = Kansas Choice PPO
6 = Coventry QHDHP

a = PPO & HMO areas (dark red)
b = PPO only areas (white)
c = Transitional areas (light red)

KANSAS

a. Allen 1,3,4,5,6
a. Anderson 1,3,4,5,6
a. Atchison 1,3,4,5,6
c. Barber 3,4,5,6
b. Barton 4,5,6
c. Bourbon 1,4,5,6
a. Brown 1,3,4,5,6
a. Butler 1,2,3,4,5,6
a. Chase 1,2,3,4,5,6
a. Chautauqua 1,2,3,4,5,6
c. Cherokee 1,4,5,6
b. Cheyenne 4,5,6
b. Clark 4,5,6
a. Clay 3,4,5,6
c. Cloud 3,4,5,6
a. Coffey 1,3,4,5,6
b. Comanche 4,5,6
a. Cowley 1,2,3,4,5,6
c. Crawford 1,4,5,6
b. Decatur 4,5,6
a. Dickinson 1,2,3,4,5,6
a. Doniphan 1,3,4,5,6
a. Douglas 1,3,4,5,6
b. Edwards 4,5,6
a. Elk 1,2,3,4,5,6
c. Ellis 1,4,5,6
a. Ellsworth 1,3,4,5,6
b. Finney 4,5,6
b. Ford 4,5,6
a. Franklin 1,3,4,5,6
a. Geary 1,3,4,5,6
b. Gove 4,5,6
b. Graham 4,5,6
b. Grant 4,5,6
b. Gray 4,5,6
b. Greeley 4,5,6
a. Greenwood 1,2,3,4,5,6
b. Hamilton 4,5,6
a. Harper 1,2,3,4,5,6
a. Harvey 1,2,3,4,5,6
b. Haskell 4,5,6
b. Hodgeman 4,5,6
a. Jackson 1,3,4,5,6
a. Jefferson 1,3,4,5,6
b. Jewell 4,5,6
a. Johnson 1,3,4,5,6
b. Kearny 4,5,6
a. Kingman 1,2,3,4,5,6
b. Kiowa 4,5,6
c. Labette 1,4,5,6
b. Lane 4,5,6
a. Leavenworth 1,3,4,5,6
a. Lincoln 1,3,4,5,6
a. Linn 1,3,4,5,6
b. Logan 4,5,6
a. Lyon 1,3,4,5,6
a. Marion 1,2,3,4,5,6
a. Marshall 1,3,4,5,6
a. McPherson 1,2,3,4,5,6
b. Meade 4,5,6
a. Miami 1,3,4,5,6
c. Mitchell 3,4,5,6
c. Montgomery 1,4,5,6
a. Morris 1,2,3,4,5,6
b. Morton 4,5,6
a. Nemaha 3,4,5,6
c. Neosho 1,4,5,6
b. Ness 4,5,6
b. Norton 4,5,6
a. Osage 1,3,4,5,6
c. Osborne 3,4,5,6
a. Ottawa 1,3,4,5,6
b. Pawnee 4,5,6
b. Phillips 4,5,6
a. Pottawatomie 1,3,4,5,6
c. Pratt 1,3,4,5,6
b. Rawlins 4,5,6
c. Reno 1,2,3,4,5,6
b. Republic 4,5,6
c. Rice 3,4,5,6
a. Riley 1,3,4,5,6
b. Rooks 4,5,6
b. Rush 4,5,6
a. Russell 1,3,4,5,6
a. Saline 1,2,3,4,5,6
b. Scott 4,5,6
a. Sedgwick 1,2,3,4,5,6
b. Seward 4,5,6
a. Shawnee 1,3,4,5,6
b. Sheridan 4,5,6
b. Sherman 4,5,6
b. Smith 4,5,6
b. Stafford 4,5,6
b. Stanton 4,5,6
b. Stevens 4,5,6
a. Sumner 1,2,3,4,5,6
b. Thomas 4,5,6
b. Trego 4,5,6
a. Wabaunsee 1,3,4,5,6
b. Wallace 4,5,6
a. Washington 3,4,5,6
b. Wichita 4,5,6
c. Wilson 1,3,4,5,6
a. Woodson 1,3,4,5,6
a. Wyandotte 1,3,4,5,6

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c. Andrew 1,4,5,6
b. Atchison 4,5,6
b. Barry 4,5,6
c. Barton 1,4,5,6
c. Bates 1,4,5,6
a. Benton 1,4,5,6
a. Buchanan 1,3,4,5,6
a. Caldwell 1,4,5,6
b. Camden 4,5,6
a. Carroll 1,4,5,6
c. Cass 1,4,5,6
a. Cedar 1,4,5,6
b. Chariton 4,5,6
a. Christian 1,4,5,6
a. Clay 1,3,4,5,6
c. Clinton 1,4,5,6
b. Cooper 4,5,6
a. Dade 1,4,5,6
a. Dallas 1,4,5,6
a. Daviess 1,4,5,6
a. DeKalb 1,4,5,6
b. Douglas 4,5,6
c. Gentry 1,4,5,6
a. Greene 1,4,5,6
a. Grundy 1,4,5,6
b. Harrison 4,5,6
a. Henry 1,4,5,6
a. Hickory 1,4,5,6
b. Holt 4,5,6
a. Jackson 1,3,4,5,6
c. Jasper 1,4,5,6
a. Johnson 1,4,5,6
b. Laclede 4,5,6
c. Lafayette 1,4,5,6
a. Lawrence 1,4,5,6
b. Linn 4,5,6
a. Livingston 1,4,5,6
b. McDonald 4,5,6
b. Mercer 4,5,6
b. Morgan 4,5,6
c. Newton 1,4,5,6
b. Nodaway 4,5,6
a. Pettis 1,4,5,6
a. Platte 1,3,4,5,6
a. Polk 1,4,5,6
b. Putnam 4,5,6
c. Ray 1,4,5,6
a. St. Clair 1,4,5,6
a. Saline 1,4,5,6
b. Stone 4,5,6
b. Sullivan 4,5,6
b. Taney 4,5,6
c. Vernon 1,4,5,6
a. Webster 1,4,5,6
b. Worth 4,5,6
b. Wright 4,5,6